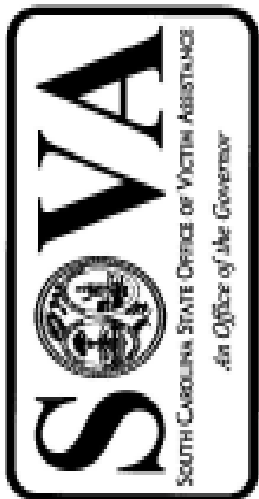


Application

for Crime Victims' Compensation



South Carolina has a Crime Victims' Compensation Fund to help citizens with costs related to injuries received in a crime. To find out more, read this information sheet or call the State Office of Victim Assistance (SOVA) at 1(800) 220-5370 or at (803) 734-1900 in Columbia.

How much help can I get from SOVA's Crime Victims' Compensation Fund?

If you qualify, you can get help with the costs of medical care, counseling, lost wages/support, for yourself as a victim, or for a victim you are financially responsible for. You may also get repaid for what you spent on the funeral of a deceased victim. The law limits the amount of these payments. The most that can be paid on behalf of a victim for all expenses combined is \$15,000. SOVA can pay for either 20 sessions or 180 days of counseling, whichever amount you use. For burials, the limit is \$4,000. Victims who have high medical bills from severe injuries may qualify for an additional \$10,000.

How do I get financial help?

If you are a victim or claimant (person filing for a victim), you must show that:

- ◆ The crime happened in this state and was reported to law enforcement within 48 hours, if possible
- ◆ You were not doing anything illegal at the time of the crime
- ◆ You or your immediate family member have incurred, or will incur, medical, counseling, funeral bills and/or lost time from work because of injuries directly resulting from the crime
- ◆ You submitted this application within 180 days from the date of the crime, if possible
- ◆ Insurance and other payment sources will not cover the bills submitted

What losses are not covered?

- ◆ Property damage or loss, to include crime scene cleanup
- ◆ Expenses related to going to court (lawyer, travel, etc.)
- ◆ "Pain and suffering"

Who can qualify for financial assistance?

Injured crime victims, immediate family members of crime victims, or someone who is paying bills or taking care of a crime victim may apply. There are some exceptions.

COMPLETING THE APPLICATION...

How can I get help with this application?

Law enforcement agencies, solicitors' offices and victim assistance groups in your area have victim advocates to help you with this form. If you are unable to reach one or don't know who to call, the Victim/Witness Assistance Program in the *State Office of Victim Assistance* (SOVA) will be glad to help you. Call us at **1-800-220-5370** between the hours of 8:00 am and 5:00 pm.

Do I have to fill out this whole packet of forms?

NO. Only part of this packet is the application for compensation benefits. Supplemental forms are included for you to give to your counselor, doctor, or employer to complete as required.

If I want to apply now, what should I do?

Read the instructions on the back of this page and fill out the attached claim application. Also include copies of as much related information (i.e. copies of itemized receipts, bills, insurance statements) as you have. The more information we have now, the sooner your application can be processed. **You need to send the application within 180 days of the crime, so do not wait to collect all of your bills.** You can send more itemized bills later as you receive them.

SOVA will send you a letter when your application is received. If you have not received a letter after four weeks, please call your local victim advocate or SOVA. Keep in touch: If you move or if your phone number changes, please let us know!

>> Section by section instructions are on the back of this sheet.

1205 Pendleton St., Brown Building Room 401, Columbia, SC 29201 ♦ Main Fax No.: (803) 734-1708

If you are...

- ◆ filing for *yourself as an adult victim*, then you are the “Applicant.”
- ◆ filing for *a minor, or an incapacitated or incompetent victim*, then you are the “Claimant,” and the crime victim should be named as the “Applicant”- (Person Receiving Services).
- ◆ filing for the medical and/or burial bills *for a deceased victim*, then you are “Claimant” and the “Person Receiving Services,” and the deceased crime victim should be named as the “Applicant.”
- ◆ filing for *counseling for yourself because an immediate family member has been injured or killed*, then you are the “Applicant” and the “Person Receiving Services.” The injured or deceased family member is the “Victim.”
- ◆ filing for *counseling for a minor because his/her immediate family has been injured or killed*, then you are the “Claimant,” the minor is the “Person Receiving Services,” and is the “Applicant”.

Print neatly and use a separate form for each appli-**SECTION 1**
“Person
Receiving
Services”

Print the name of the person who needs or is getting medical attention, counseling or other services because of the crime. The “Person Receiving Services” is the Victim and/or the Applicant.
Please check requested services.

If you are the person injured at the crime scene, this should be the same person listed as the “Victim” on the law enforcement report. Complete the rest of this block with information about the victim.

SECTION 2
“Claimant”

If you are filing on behalf of a minor or you are the adult who is assuming responsibility for the crime-related bills. This person is the “Claimant.” If the Person Receiving Services is an adult responsible for his or her own bills, then also put his or her name here as the Claimant. If the Person Receiving Services is under 17, incapacitated or incompetent, then the financially responsible person (e.g. parent, guardian, spouse) should be named here. If the Victim died as a result of the crime, then the adult handling the deceased’s medical and/or burial bills is both the Person Receiving Services and Claimant.

SECTION 3
“Crime”

Be specific in describing injuries and harm to the victim. Attach a copy of the incident report. If you don’t have one, you can get one for free from the law enforcement agency that took the information about the crime. **The law enforcement incident report on the crime is necessary to determine eligibility and process the claim.**

>> Detach application along perforated edge and flip upside down to complete sections 5 - 10. <<

SECTION 4
“Expense”

List the names of doctors, hospitals, and others who have provided services. If you already have itemized bills, please send copies with your application. **If you have not received bills, do not wait on them.** You may send copies later as you receive them. SOVA can only pay for **counseling from a licensed counselor**. Your counselor must send SOVA a completed **Counselor’s Report** relating the mental health treatment to the crime. This form is in the booklet marked “Supplemental Forms.”

SECTION 5
“Insurance”

If you have insurance that may cover some of your crime-related bills, list your insurance information here.

SECTION 6
“Employment”

List your job information **if you have not been able to work for at least two weeks in a row because of crime-related injuries or to take care of someone with crime related injuries.** Your employer will need to complete the **Employer’s Report**, giving us your average weekly wage and time missed from work. The doctor treating the Victim will need to complete the **Physician’s Report**, telling us that the absence from work is medically necessary because of the crime. Both forms are included in the booklet marked “Supplemental Forms.” For “Loss of Support,” please call our office to see if you are eligible.

SECTION 7
“Civil Action”

If you hired a lawyer to settle an insurance claim or file a lawsuit related to this crime, complete this section.

SECTION 8
“Referral”

Print the name of the victim advocate or other professional who assisted you with this application.

SECTION 9
“Authorization”

Important: This application is a legal document which must be read and signed by the adult Claimant.

State Office of Victim Assistance ♦ 1205 Pendleton St., Brown Building Room 401, Columbia, SC 29201 ♦ 1(800) 220-5370 or (803) 734-1900

Please call a local victim advocate or our office for help with completing this form. Use a separate form for each person filing a claim.

Section 1 Applicant-Person Receiving Services

If you are the victim, your name must be listed as on the incident report.

(circle one)

Mr./ Mrs./ Ms.

Full Legal Name of Individual Receiving Services/Benefits

Sex: Male _____ Female _____

Social Security Number

Date of Birth

This information is requested for statistical reporting purposes, and is optional. Marital Status: _____

Race: ___ Caucasian ___ African American ___ Hispanic ___ Native American ___ Asian or Pacific Islander ___ Other: _____

Home Mailing Address

City/County

State

Zip Code

Home Telephone Number

Other contact number(s)

The person receiving services is the _____ Victim (as identified on the incident report upon which this claim is based)

Victim's name if different than applicant _____

OR, the Victim's ___ Spouse ___ Parent ___ Sibling ___ Child ___ Other: _____

Check services requested: ___ Medical ___ Counseling ___ Lost Wages/Support ___ Burial ___ Other: _____

Section 2 Claimant Information

Complete only if: The Claimant is the adult assuming responsibility for the crime-related bills and/or the adult that has physical custody of a minor.

(circle one)

Mr./ Mrs./ Ms.

Relationship to Victim: _____

Full Legal Name

Social Security Number _____ Date of Birth _____ Marital Status _____ Sex _____

Check if Victim is: ___ deceased ___ under 17 ___ incompetent ___ disabled

Home Mailing Address(if different from above)

City/County

State

Zip Code

Home Telephone Number

Other contact numbers SOVA may use (i.e. work, cellular phone, fax)

Section 3 Crime Information

Attach a copy of the law enforcement incident report.

If law enforcement was not contacted, an incident report was not written within 48 hours of the crime, or if you are not filing this claim with SOVA within 180 days of the crime, please explain why: _____

Date of Crime

Date Reported

Name of Law Enforcement Agency

Location/Address of Crime

City/County

State

Incident Report Number

Type of Crime and Brief Description of the Incident

Type of Injury

Name(s) of Offender(s)

Relationship of Offender(s) to Victim

Warrant No.(s)

Has the case gone to court? ___ Yes ___ No

Please indicate the type of court: _____ Magistrate _____ Municipal _____ General Sessions _____ PTI

If yes, how much restitution was ordered? ___ None or Amount Ordered \$ _____ and Amount Paid to Date \$ _____

Section 4 Crime-Related Expense Information*

Attach copies of itemized bills, and additional pages as neces-

Name of:

Services Provided from (date) to (date)

Phone #

Doctor/Hospital

Counselor

Funeral Home

Section 5 Health Insurance / Benefits Informa-List insurance policies including Medicaid and Medi-**Section 6 Lost Wages / Support Informa-**

Complete if you have not been able to work for at least two weeks in a row because of your injuries or to take care of an injured victim.

Employer's Name

Telephone Number

Fax Number

Employee's Name

Name and Address of Company/Business (*If more than one employer, please attach additional sheets.*)

Circle Yes or No - If injured on the job, does your employer have Workers' Compensation? Yes No
Have you, or will you, file for Social Security disability (SSI)? Yes No

Is your household losing income/paychecks due to the crime? Yes No Are you missing work to care for the victim? Yes No

Section 7 Civil Action Information

Have you hired a lawyer to settle with insurance or file a lawsuit? ___ Yes ___

If yes, please provide:

Name of Lawyer

Mailing Address

Telephone Number

Section 8 Referral Source Information

___ Solicitor ___ LEVA ___ Hospital/Dr. ___ Counselor ___ Other___

Name/Title of Professional Assisting with Application

Telephone Number

Fax Number

Agency/Office

Mailing Address (include P.O. Box or street)

city and county,

state,

zip code

Section 9 Legal Authorization & Signature*This document is in compliance with the HIPAA guidelines.*

I understand that I am responsible for all bills and the compensation program is designed to pay certain costs not covered by another source. Submitting this application does not entitle me to benefits. I authorize the State Office of Victim Assistance (SOVA) to request, obtain, and release any information or records to determine the eligibility of my claim for a period not to exceed the full processing of this application. I further understand that there is a potential for me to no longer be protected by the Privacy Rule, and that I have the right to revoke this authorization in writing at any point I so desire. I agree to repay SOVA if I receive money from another source, up to the amount paid on my behalf. This includes any payment I may receive from the offender, any insurance policy or settlements, judgments, or civil law suits. I agree to notify SOVA of any changes, such as address or phone numbers, to maintain accuracy in the processing of this claim.

The information I have provided is true and correct to the best of my knowledge under penalty of law (§16-3-1280).

Original Signature of Victim/Claimant _____ Date _____

[Legal representative must sign if the Victim is under 17, legally declared incompetent or deceased.]